(For Office Use Only)

Application Fee Paid _____ Date of Registration _____

WEST HARTFORD-BLOOMFIELD HEALTH DISTRICT

PHONE: (860) 561-7900 **FAX**: (860) 561-7918

Massage Therapy Establishment Permit Application

Name of Establishment: _____

Address of Establishment: _____
Street Town State Zip Code

Business Phone Number: _____ **Fax Number:** _____

Email: _____ **Emergency Phone Number:** _____

Name of Applicant: _____ _____ _____
Last First M.I.

Applicant Home Address: _____
Street Town State Zip Code

Applicant Phone Number: _____ **Applicant Date of Birth:** _____

Please enclose:

- **A non-refundable fee of seventy-five dollars ($75).**
- **A photocopy of the applicant's current CT Driver's License or other valid photo ID.**
- **Photocopies of employees' State of Connecticut Massage Therapist licenses and current CT driver's licenses or other valid photo ID's.**

I agree to operate this massage therapy establishment in accordance with the Town of West Hartford Massage Therapy Establishment Ordinance. I understand that, as the applicant, I am responsible for the massage therapy establishment. I understand that any questions not answered or any false or misleading answers contained herein shall be grounds for immediate rejection of this application or closure of the massage therapy establishment registered hereunder.

_____ _____
Signature of Applicant Date